Interjurisdictional Tuberculosis Notification

Referring
Jurisdiction city _____ county _____ state _____ Date sent ____/____/____
Contact person _____ Phone ( ) _____ FAX ( ) _____

☐ Verified case State reporting to CDC: _____ RVCT# _____ (attach RVCT) ☐ Not reported _____
☐ Suspect case ☐ Close contact ☐ Reactor (LTBI) ☐ Convertor (LTBI) ☐ Source case investigation

Patient name _____ Sex ☐ M ☐ F
Last First Middle

AKA _____

Date of birth ____/____/____ Interpreter needed? ☐ No ☐ Yes, specify language _____
New address _____ Hispanic ☐ No ☐ Yes
Number/Street/Apt. Race ☐ White ☐ Black ☐ Asian
☐ Am.Indian/Nat.Alaskan.
_____ ☐ Other: _____
City/State/ZipCode

New telephone ( ) _____ Date of expected arrival ____/____/____
New health provider ☐ Unknown ☐ Known (name, address, phone) _____
Insurance source: ☐ None ☐ Medicaid ☐ Private ☐ Medicare ☐ Other _____
Emergency contact: Name _____ Phone ( ) _____
Relationship _____

Clinical information for ☐ this referred case/suspect ☐ index case for this contact ☐ not applicable

Date of Collection	Specimen type	Smear	Culture	Susceptibility	Chest X-ray	Other pertinent labs

Site(s) of disease: ☐ Pulmonary ☐ Other(s) specify all _____
Date 1st negative smear ____/____/____ ☐ Not yet Date 1st negative culture ____/____/____ ☐ Not yet
TB skin test #1:Date ____/____/____ Result ____mm TB skin test #2: Date ____/____/____ Result ____mm

Contact/LTBI Information **TB Skin test** ☐ Not Done
TST #1 Date ____/____/____ Result ____mm TST#2 Date ____/____/____ Result ____mm
CXR ☐ Not Done Date ____/____/____ ☐ Normal ☐ Other: _____
Last known exposure to index case ____/____/____ Place/intensity of exposure: _____

Medications ☐ this referred case/suspect ☐ this referred contact/LTBI

Drug	Dose	Start date	Stop date

Planned completion date ____/____/____
DOT ☐No ☐ Yes: start date ____/____/____
☐ Daily ☐ 1x W ☐ 2x W ☐ 3x W
Last DOT Date ____/____/____
Adherence problems/significant drug side effects:
_____
_____
_____

Comments _____
_____
_____

Case Follow-Up Within 30 days report to referring jurisdiction if located or not located and report final outcome when available.
Other Follow-Up ☐ Follow-up requested (form attached) ☐ No follow-up requested

Interjurisdictional TB Notification Follow-up Form

Date Received: ____/____/____ 30-day status: ☐ located ☐ not located

Return to:

Name _____ Fax number _____

Jurisdiction _____ Phone number _____

Patient name _____ Date of birth ____/____/____
Last First Middle

New address _____
Number Street/Apt. City State Zip Code

New telephone ( )_____ Sex ☐ Male ☐ Female

☐ **Case:** (Send RVCT F/U2 to reporting jurisdiction)

- ☐ Completed: ____/____/____
- ☐ Moved to: city _____ county _____ state _____ Date: ____/____/____
- ☐ Lost (after initially located) ☐ Never located ☐ Uncooperative or refused
- ☐ Not TB ☐ Died ____/____/____ ☐ Other_____

☐ **Suspect:**

- ☐ Verified by lab ☐ Verified by clinical definition
- ☐ Verified by provider diagnosis ☐ Not verified
- ☐ Other:_____

If verified, and original jurisdiction submits RVCT, complete case outcome above

☐ **Contact:**

- ☐ No follow-up performed ☐ Never located
- ☐ Evaluated: ☐ Class II ☐ Class III ☐ Class IV ☐ No infection
- ☐ Started treatment ☐ Continuing treatment
- ☐ Completed treatment ☐ Other:_____

☐ **LTBI:**

- ☐ No follow-up performed ☐ Never located ☐ Started treatment
- ☐ Continuing treatment ☐ Completed treatment ☐ Other:_____

Person completing form_____ Date completed ____/____/____